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# Beneficiary Complaints: How to Respond to Appeals, Grievances and Redeterminations

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# **Session Overview**

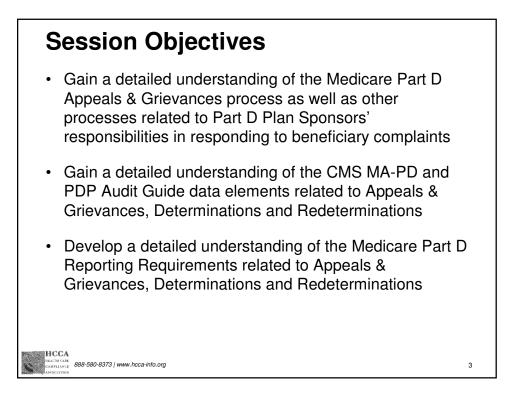
- Part D Sponsor Responsibilities
- Appeals & Grievances Common issues, challenges and mistakes
- · Part D CMS Audit Guide Elements
- Part D Reporting Requirements
- Appeals & Grievances Case Study
- Appendix

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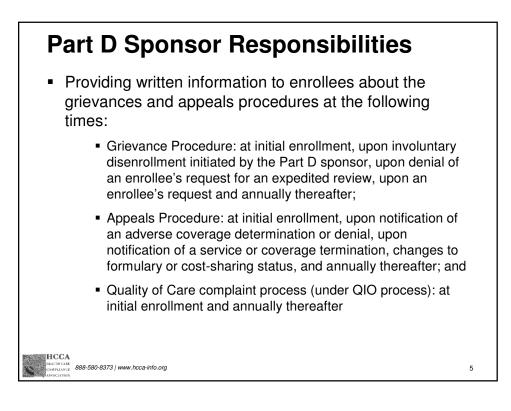
- Key Terms
- MA-PD and PDP Audit Guide Elements
- CY 2008 Medicare Part D Reporting Requirements
- References

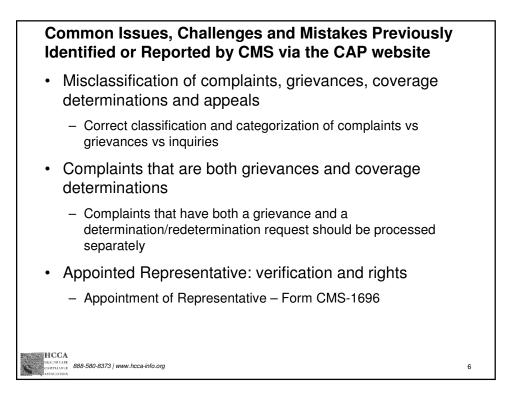
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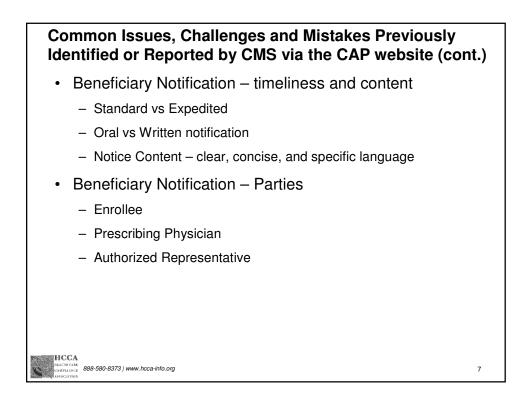
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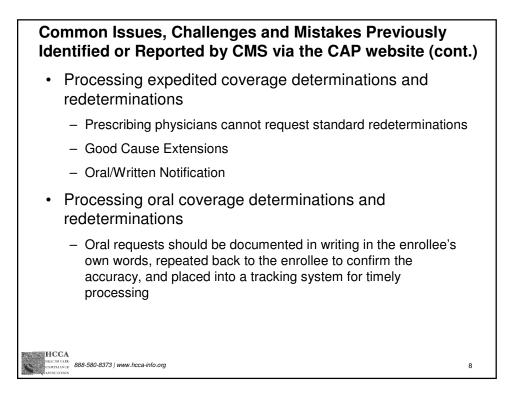


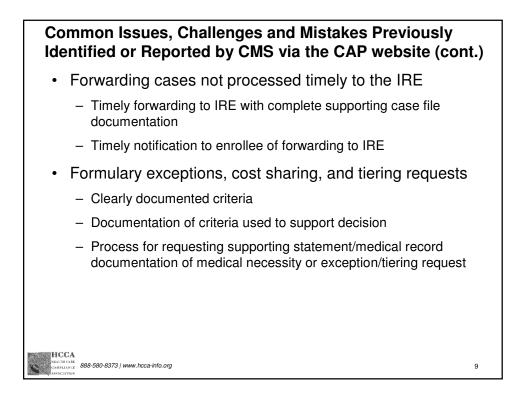
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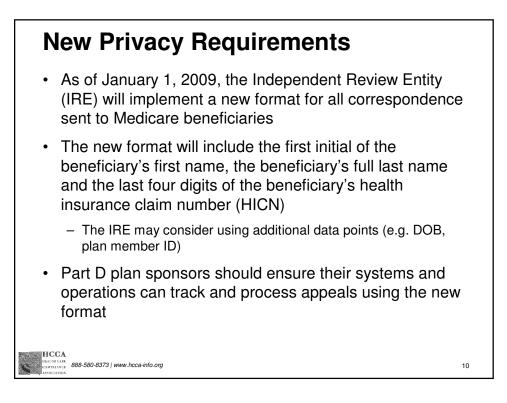












Area	Timelines
Filing an Appeal / Grievance / Request for IRE review or Higher Level Review	60 days from date of decision/notice
Coverage	Standard Process: 72 hour time limit*
Determination Decision	Expedited Process: 24 hour time limit*
Redetermination	Standard Redetermination: 7 day time limit*
Decision	Expedited Redetermination: 72 hour time limit*
IRE Review (Second	Standard Reconsideration: 7 day time limit
Level of Appeal)	Expedited Reconsideration: 72 hour time limit

Area	Timelines
Administrative Law Judge (ALJ) Review	No statutory time limit for processing*
Medicare Appeals Council (MAC) Review	No statutory time limit for processing
Federal District Court	No statutory time limit for processing*
Federal District Court	No statutory time limit for processing*

# **Appeals & Grievances - Examples**

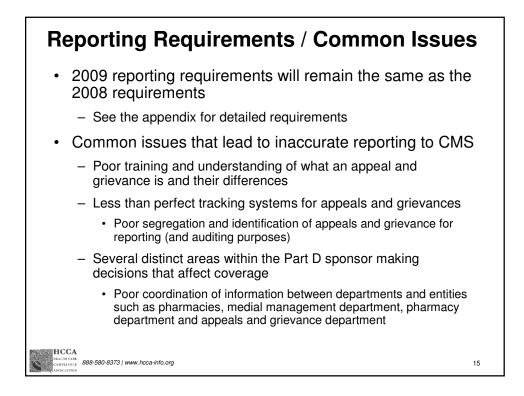
Complaints may include both appeals and grievances. A Part D sponsor must determine if the issues in an enrollee's complaint meet the definition of an appeal or grievance or both.

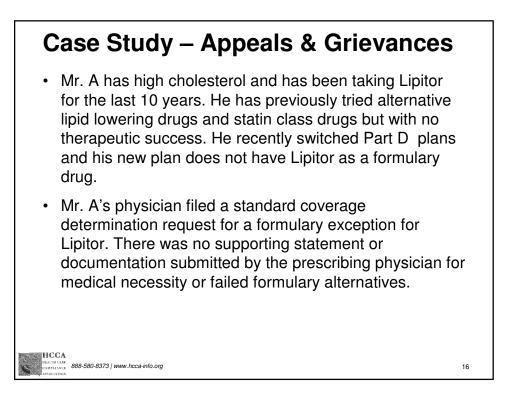
Example	Appeal	Grievance
Complaint about co-payments	Х	x
<ul> <li>An enrollee expresses general dissatisfaction about a co- payment amount.</li> </ul>		x
<ul> <li>An enrollee believes that a Part D sponsor has required the enrollee to pay an amount for a drug that should be the sponsor's responsibility.</li> </ul>	x	
A request by a member to continue to take his/her high cholesterol medication that he/she has taken for years but the medication is not a part of the plan's Part D formulary.	N/A	N/A
A complaint by an enrollee who is upset that a specialist that he/she currently uses will no longer be a contracted provider.	X	x
A complaint about a denial of an enrollee's request for an expedited coverage determination.	Х	

# **Examples (Cont.)**

Complaints may include both appeals and grievances. A Part D sponsor must determine if the issues in an enrollee's complaint meet the definition of an appeal or grievance or both.

Example	Appeal	Grievance	
An enrollee calls to complain that it has been two weeks since he/she filed a request for a drug coverage determination but has not received a decision from the plan sponsor regarding the determination request.		x	
An enrollee generally fills his prescriptions via mail order but encounters problems with the online pharmacy's website and decides to go to a non-network walk-in pharmacy. Because of the plan design, the enrollee has to pay a higher co-pay because he went to a non- network pharmacy and went to a walk-in pharmacy rather than mail- order. The enrollee calls the Part D sponsor complaining about the online pharmacy's website being down and requests that the sponsor reimburse the member for the difference in the co-pay.		x	
A complaint by an enrollee that a drug that he/she is currently taking is not a part of the Part D sponsor's formulary.	X	x	
An enrollee that wants to know if a drug that he/she is taking is a part of the plan's Part D formulary	N/A	N/A	



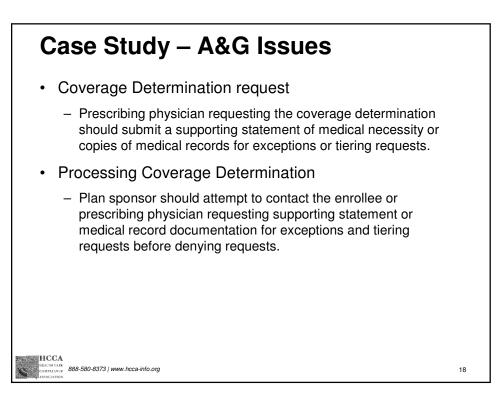


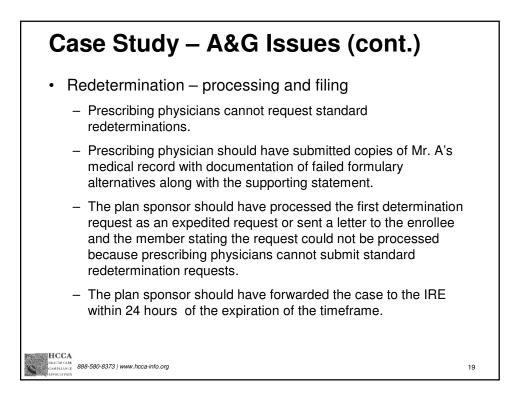
# **Case Study – Appeals & Grievances**

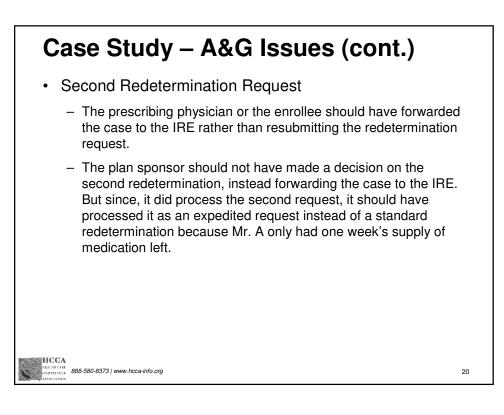
- The plan denied the request stating Mr. A try a formulary drug. Mr. A's physician filed a standard redetermination request with the supporting statement of failed therapeutic success of formulary alternatives in the past but no copies of Mr. A's medical record.
- Two weeks passed and neither Mr. A nor his physician received a response from the plan sponsor. Mr. A's physician resubmitted the standard redetermination requesting a response because Mr. A only had a week's supply of medication left. One week later, the plan responded with a decision that reversed it's original coverage determination.

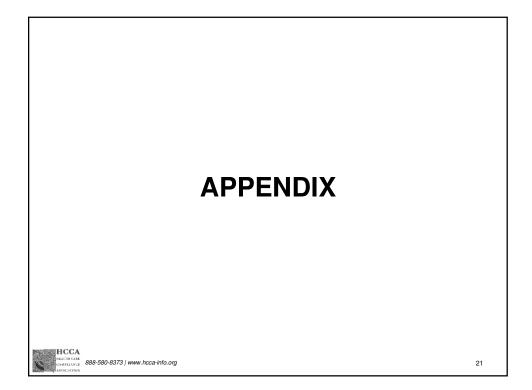
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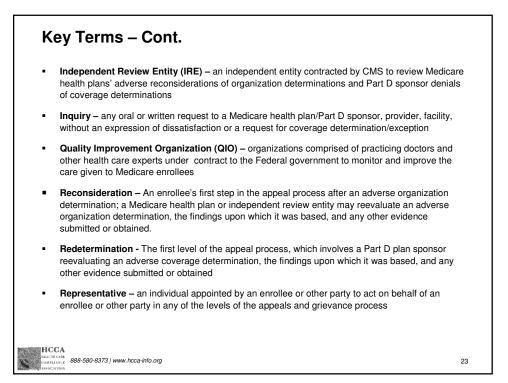


# Key Terms

- Appeal Any of the procedures that deal with the review of adverse organization and coverage
  determinations on the health care services or Part D benefits an enrollee believes he or she is
  entitled to receive. These procedures include reconsiderations, redeterminations, reconsiderations
  by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, reviews by the
  Medicare Appeals Council (MAC), and judicial reviews.
- Complaint any expression of dissatisfaction to a Medicare health plan or Part D sponsor, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing; may involve a grievance, coverage/organization determination or both
- Coverage Determination any decision made by or on behalf of a Part D sponsor regarding
  payment or benefits to which an enrollee believes he or she is entitled
- Effectuation compliance with a partial or complete reversal of a Medicare health plan/Part D sponsor's original adverse coverage/organization determination. Compliance may entail payment of a claim, or authorization of a service or provision of services
- Enrollee a MA or Part D eligible individual that that elected a MA or Part D plan
- Grievance any complaint or dispute, other than one involving an organization/coverage determination, or an LIS or LEP determination, expressing dissatisfaction with the manner in which a Medicare health plan or Part D sponsor provides health care services, regardless of whether any remedial action can be taken

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		Grievances
K X	X	Organization Determinations and Reconsiderations Not Categorized as Grievances (Complaint Categorization)
		Grievance Adjudication Grievance Decision Notification (Timeliness)
	X	Grievance Decision Notification (1 ineliness) Grievance Decision Notification (Notice Content)
	X	Method of Grievance Decision Notification (Response)
	x	Grievance Policies and Procedures
	x	Grievance Process Training
	x	Grievance Response - Quality of Care
	X	Timely Response to Expedited Grievances
	x	Coverage Determinations
x x	Х	Notices in Network Pharmacies
x x	X	Coverage Determination Policies and procedures
x x	Х	Timely Notification of Coverage Determination Concerning Drug Benefit
к х	Х	Coverage Determinations Concerning Payment
к х	Х	Denial Notice Requirements for Coverage Determinations
к х	Х	Decision to Accept or Deny Request for Expedited Coverage Determination
х х	Х	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination
x x	x	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination
x x	x	Timely Notification of Expedited Coverage Determination
K K		Timely Notification Following Decision to Deny Request for Expedited Coverage Determination Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination Timely Notification of Expedited Coverage Determination Notice Content Requirements for Expedited Coverage Determination

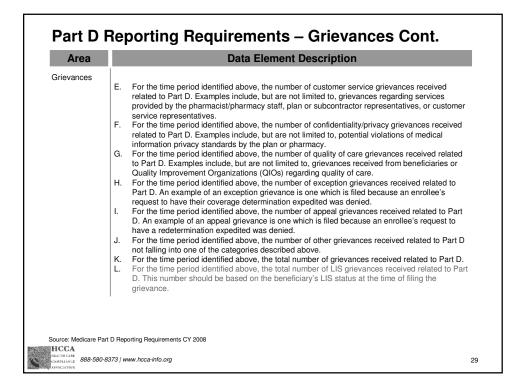
# Part D Audit Guide Elements (Cont.)

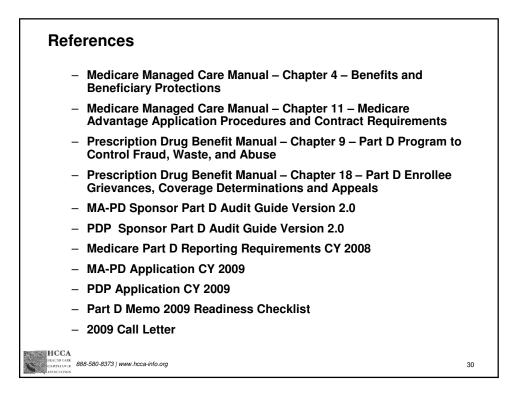
		MA-PI	) PDI
Exception	ns		
E	Exceptions Procedures and Criteria (Tiered Cost Sharing)	X	X
E	Exceptions Procedures and Criteria (Non-Dormulary Drugs)	X	X
A	Approval of Tiering and Non-Formulary Exceptions Requests	X	X
Redetern	ninations		
R	Request for Redeterminations (Standard)	Х	X
R	Request for Redeterminations (Expedited)	Х	X
D	Decision to Accept or Deny Raquest for Expedited Redetermination	X	X
A	Actions Following Decision to Deny Request for Expedited Redetermination	X	X
Т	imely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit	X	X
Т	imely Notification and Effectuation of Standard Redetermination Concerning Payment	X	X
Т	imely Notification of Expedited Redetermination and Request for Medical Information	X	X
E	expedited Coverage Redetermination Reversals	X	X
R	Review of Adverse Coverage Determinaitons	X	X
Т	imely Transfer of IRE Upon Reconsideration Request	X	X
Reversal	s by Other Than Part D Sponsors		
E	ffectuation of Third Party Reversals - Benefits (Standard)	Х	X
E	ffectuation of Third Party Reversals - Payments (Standard)	Х	Х
~	iffectuation of Third Party Reversals - Benefits (Expedited)	Х	X

Area	Data Element Description
Appeals	<ul> <li>A. The number of appeals submitted for standard redetermination in the time period specified above. (Do not include those appeals that were submitted as expedited redeterminations and were not granted expedited status.)</li> <li>B. The number of appeals submitted for expedited redetermination in the time period specified above.</li> <li>C. The number of appeals submitted for expedited redetermination that were granted expedited status in the time period specified above.</li> <li>D. The number of appeals submitted for expedited redetermination that were granted expedited status in the time period specified above.</li> <li>D. The number of appeals submitted for standard redetermination withdrawn by the enrollee in the time period specified above.</li> <li>E. The number of appeals submitted for expedited redetermination withdrawn by the enrollee in the time period specified above.</li> <li>F. The number of redeterminations in the time period specified above resulting in full reversal of original decision.</li> <li>G. The number of redeterminations in the time period specified above due to insufficient evidence of medical necessity from enrollee's prescribing physician. Examples of insufficient evidence of medical necessity may include, but are not limited to, when the plan does not receive the information, or the information received does not support medical necessity.</li> </ul>
	uirements for Appeals includes data for coverage determinations, redeterminations by the Plan and reconsiderations by the IRE. art D Reporting Requirements CY 2008

Area	Data Element Description	
Appeals	<ol> <li>The number of appeals submitted for IRE reconsideration in the time period specific above due to inability to meet timeframe for coverage determination.</li> <li>The number of appeals submitted for IRE reconsideration in the time period specified above due to inability to meet timeframe for redetermination.</li> <li>K. The number of IRE decisions for standard reconsideration in the time period specified above resulting in full reversal of original coverage determination or redetermination.</li> <li>The number of IRE decisions for standard reconsideration in the time period specified above resulting in partial reversal of original coverage determination or redetermination.</li> <li>The number of IRE decisions for standard reconsideration in the time period specified above resulting in partial reversal of original coverage determination or redetermination.</li> <li>M. The number of IRE decisions for expedited reconsideration in the time period specified above resulting in full reversal of original coverage determination or redetermination.</li> <li>N. The number of IRE decisions for expedited reconsideration in the time period specified above resulting in partial reversal of original coverage determination or redetermination.</li> <li>N. The number of IRE decisions for standard reconsideration in the time period specified above resulting in partial reversal of original coverage determination or redetermination.</li> <li>O. The number of IRE decisions for standard reconsideration in the time period specified above resulting in upholding of original coverage determination or redetermination.</li> <li>P. The number of IRE decisions for expedited reconsideration in the time period specified above resulting in upholding of original coverage determination or redetermination.</li> </ol>	
	rements for Appeals includes data for coverage determinations, redeterminations by the Plan and reconsiderations by the IRE. t D Reporting Requirements CY 2008	

Area	Data Element Description
Grievances	<ul> <li>A. For the time period identified above, the number of fraud and abuse grievances received related to Part D. A fraud grievance is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Plan, Plan Agent or broker, or beneficiary engaged in the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. An abuse grievance is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Plan, Plan Agent or broker or beneficiary engaged i behavior that the individual should have known to be false, and the individual should have known that the deception could result in some unauthorized benefit to himself/herself or some other person.</li> <li>B. For the time period identified above, the number of enrollment/disenrollment grievances received related to Part D. Examples include, but are not limited to, discrimination in the enrollment process, enrollment information and/or identification cards not being received by beneficiaries in timely manner, and disenrollment requests not being processed in a timely manner.</li> <li>C. For the time period identified above, the number of benefit package grievances received related to Part D. Examples include, but are not limited to, newfork pharmacy access/network grievances receiver issues and issues related to coverage during the coverage gap period.</li> <li>D. For the time period identified above, the number of marketing grievances received related to Part D. Examples include, but are not limited to, newfork pharmacy refusing to accept a beneficiary's card and network/non-network pharmacy concerns.</li> <li>E. For the time period identified above, the number of marketing grievances received related to Part D. Examples include, but are not limited to, network pharmacy access/network grievances received related to Part D. Examples incl</li></ul>
Source: Medicare Pa	t D Reporting Requirements CY 2008





# **Contact Information**

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